Medicare Payments for Part B Mental Health Services

The Office of Inspector General (OIG) recently studied the appropriateness of Medicare Part B payments for mental health services and recommended that we promote provider awareness of the requirements for payment of these services. OIG reports can be accessed at http://www.oig.hhs.gov/oei/oeisearch.html. This article explains Medicare's guidelines for payment of Part B mental health services including qualification requirements for mental health providers; incident to services; reasonable and necessary services; reasonable expectation of improvement; general principles of medical record documentation; documentation guidelines for evaluation and management (E/M) services involving a general psychiatric examination or the single system psychiatric examination; and documentation guidelines for psychiatric diagnostic or evaluative interview procedures, psychiatric therapeutic procedures, central nervous system assessment, and health and behavior assessment.

Qualification Requirements for Mental Health Providers

Providers of mental health services must be qualified to perform the specific mental health services that are billed to Medicare. In order for services to be covered, mental health professionals must be working within their State Scope of Practice Act and licensed or certified to perform mental health services by the State in which the services are performed. Qualification requirements for mental health professionals are listed below.

- **A qualified physician must:**

(1) Be legally authorized to practice by the State in which he/she performs the functions or actions, and

(2) Be acting within the scope of his/her license.

- **A clinical psychologist must**:

(1) Hold a doctoral degree in psychology; and

(2) Be licensed or certified, on the basis of the doctoral degree in psychology, by the State in which he/she practices, at the independent practice level of psychology to furnish diagnostic, assessment, preventive, and therapeutic services directly to individuals.

Refer to regulations found at 42 CFR §410.71 and the Medicare Carriers Manual Part 3, Chapter II, §2150 for the covered services of a clinical psychologist.

- **A clinical social worker must**:

(1) Possess a master's or doctor's degree in social work;

(2) After obtaining the degree, have performed at least two years of supervised clinical social work; and

(3) Be licensed or certified as a clinical social worker by the State in which the services are performed.

In States that do not provide for licensure or certification as a clinical social worker, the individual must:

(1) Be licensed or certified at the highest level of practice provided by the laws of the State in which the services are performed; and

(2) Have completed at least two years or 3,000 hours of post-master's degree supervised

clinical social work practice under the supervision of a master's degree level social worker in an appropriate setting such as a hospital, skilled nursing facility, or clinic.

Refer to regulations found at 42 CFR §410.73 and the Medicare Carriers Manual Part 3, Chapter II, §2152 for the covered services of a clinical social worker.

- **A nurse practitioner must:**

(1) Be a registered professional nurse who is authorized to practice as a nurse practitioner delivering mental health services by the laws of the State in which services are furnished; and

(2) Be certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, or be:

- A registered professional nurse who is authorized to practice as a nurse practitioner by the laws of the State in which the services are furnished, and has been granted a Medicare billing number as a nurse practitioner by December 31, 2000;

- A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2001; or

- A nurse practitioner who meets the above standards and applies for a Medicare billing number for the first time on or after January 1, 2003, and possesses a master's degree in nursing.

Refer to regulations found at 42 CFR §410.75 and the Medicare Carriers Manual Part 3, Chapter II, §2158 for the covered services of a nurse practitioner.

- **A clinical nurse specialist must**:

(1) Be a registered nurse who is currently licensed to practice in the State where he/she practices and authorized to perform the services of a clinical nurse specialist in accordance with State law;

(2) Have a master's degree in a defined clinical area of nursing from an accredited educational institution; and

(3) Be certified as a clinical nurse specialist by the American Nurses Credentialing Center.

Refer to regulations found at 42 CFR §410.76 and the Medicare Carriers Manual Part 3, Chapter II, §2160 for the covered services of a certified nurse specialist.

- **A physician assistant must:**

(1) Be a physician assistant who is licensed to practice as a physician assistant by the laws of the State in which services are furnished; and

(2) Have graduated from a physician assistant educational program accredited by the Commission on Accreditation of Allied Health Education Programs, or passed the national certification examination administered by the National Commission on Certification of Physician Assistants.

Refer to regulations found at 42 CFR §410.74 and the Medicare Carriers Manual Part 3, Chapter II, §2156 for the covered services of a physician assistant.

Incident to Services

Certain nonphysician practitioners such as clinical psychologists, nurse practitioners, clinical nurse specialists, and physician assistants may have services furnished incident to their professional services. To the extent that they are licensed or authorized by the State to furnish mental health services, these practitioners could have others provide some services as an incident to overall mental health services. There is no national policy that specifies the qualifications for individuals who may furnish these incidental services. In the absence of national policy, contractors can implement local medical review policies that determine who can furnish mental health services incident to the professional services of these specific nonphysician practitioners. Therefore, inconsistencies may be found in policy in terms of billing and payment to nonphysician practitioners for incident to mental health services. The requirements found in the Medicare Carriers Manual Part 3, Chapter II, §2050.1 are also applicable to services furnished incident to the professional services of certain nonphysician practitioners.

Refer to the following requirements found on the American Psychological Association's (APA) web site at http://www.apa.org/practice/medincident.html:

- Qualifications of Ancillary Personnel

- Graduate Medical Education (GME). (Current psychiatric residency programs require the teaching physician to be present during the "key portion" of any service in which a resident is involved. This would require either direct observation of the service, or use of a one-way mirror or video equipment (emphasis added). Thus, if psychiatry interns provide services, they must be observed.)

Reasonable and Necessary Services

Section 1862(a)(1)(A) of the Social Security Act states that all Medicare Part B services, including mental health services, must be "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member." For every service billed, providers must indicate the specific sign, symptom, or patient complaint necessitating the service.

Partial hospitalization programs are structured to provide intensive psychiatric care through active treatment for patients who would otherwise require inpatient psychiatric care. These programs are used to prevent psychiatric hospitalization or shorten an inpatient stay and transition the patient to a less intensive level of care.

Reasonable Expectation of Improvement

Services must be for the purpose of diagnostic study or be reasonably expected to improve the patient's condition. The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization and improve or maintain level of functioning. The goal of a course of therapy is not necessarily restoration of the patient to the level of functioning exhibited prior to the onset of illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that a patient's condition would deteriorate, relapse further, or require hospitalization if treatment services are withdrawn, this criterion would be met.

General Principles of Medical Record Documentation

Medical record documentation is required to record pertinent facts, findings, and observations about a patient's health history including past and present illnesses, examinations, tests, treatments, and outcomes. The medical record chronologically documents the care of the patient, and is an important element contributing to high quality care. It also facilitates:

- The ability of providers to evaluate and plan the patient's immediate treatment and monitor his/her health care over time;
- Communication and continuity of care among providers involved in the patient's care;
- Accurate and timely claims review and payment;
- Appropriate utilization review and quality of care evaluations; and
- Collection of data that may be useful for research and education.

The general principles of medical record documentation for reporting of medical and surgical services for Medicare payments include the following, if applicable to the specific setting/encounter:

- Medical records should be complete and legible;
- Documentation of each patient encounter should include:
  - Reason for encounter and relevant history;
  - Physical examination findings and prior diagnostic test results;
  - Assessment, clinical impression, and diagnosis;
  - Plan for care; and
  - Date and legible identity of observer;
- If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred;
- Past and present diagnoses should be accessible for treating and/or consulting physician;
- Appropriate health risk factors should be identified;
- Patient's progress, response to changes in treatment, and revision of diagnosis should be documented; and
- CPT and ICD-9-CM codes reported on health insurance claim form should be supported by documentation in the medical record.

Documentation Guidelines for E/M Services Involving a General Psychiatric Examination or the Single System Psychiatric Examination

- Providers should thoroughly familiarize themselves with documentation guidelines for E/M services. These guidelines are available on the Centers for Medicare & Medicaid Services (CMS) web site at http://www.cms.hhs.gov/medlearn/emdoc.asp.
- The Medicare Resident & New Physician Training manual, Chapter 6, (March 2002 edition) also contains the latest revisions to documentation guidelines for E/M services. Publication is available at http://www.cms.hhs.gov/medlearn or upon request from the Medicare Learning Network at medlearn@cms.hhs.gov.

Documentation Guidelines for Psychiatric Diagnostic or Evaluative Interview Procedures, Psychiatric Therapeutic Procedures, Central Nervous System Assessment, and Health and Behavior Assessment

- Providers should follow the documentation guidance for psychiatric diagnostic or evaluative interview procedures and psychiatric therapeutic procedures (CPT codes 90801 – 90802, 90804 – 90899 under the Psychiatry Section), overview and definitions for central nervous system assessment (CPT codes 96100 – 96117), and health and behavior assessment (CPT codes 96150 – 96155) as described in the Physicians' Current Procedural Terminology, which is an annual publication developed by the American Medical Association (AMA). Available from the AMA at http://www.ama-assn.org/ama/pub/category/3113.html.

- Refer to Program Memorandum A-02-129 dated January 3, 2003 for the 2003 update of the Hospital Outpatient Prospective Payment System (OPPS), which provides current revenue and HCPCS codes for the Partial Hospitalization Program.

- Providers should confer with the local carrier to determine if a local medical review policy has been written regarding documentation requirements.